Kentucky Medical Assistance Program

Overview of Proposed Medicaid Inpatient Prospective Payment System

Kentucky Department for Medicaid Services
Prospective Payment System

The DMS has adopted the Medicare Prospective Payment System approach. Generally, all rates, relative weights, and payment logic were adopted from Medicare. The relative weights have been adjusted for Medicaid average length of stay, and budget neutrality.

Who / What is excluded from DRG's

- Facilities with Critical Access Designation;
- Freestanding Rehab Hospitals;
- Freestanding Ventilator Hospitals;
- Psychiatric Services, whether performed in a Freestanding facility or as a department in acute care facilities;
- Transplants, *other than Kidney*, *Pancreas*, *and Cornea*, will continue to be reimbursed under current regulation.

Grouper

Inpatient cases will be classified into a diagnosis related group according to the 2003 Medicare Grouper.

Base Rates

For the purposes of payment under the Kentucky Medicaid DRG system, October 1, 2002, base rates have been adopted from Medicare. The base rate includes operating and capital payment components.

Operating Rate Component

- The operating rate is a per discharge amount divided into a labor-related and nonlabor component.
- Labor-related component is adjusted by a wage index applicable to the area where the hospital is located.
- Includes payment for operating indirect medical education expenses.

Capital Rate Component

- Capital rate (Adjusted Federal Capital Rate) is a per discharge amount adjusted for geographical differences and, if applicable, adjusted to reflect increased capital resource requirements of large urban areas.
- Includes capital indirect medical education payment amount.

Relative Weight Calculations

- Relative weights are adopted from Medicare, as published in the Federal Register, but are adjusted to reflect Kentucky Medicaid population experience and budget neutrality.
- Kentucky Medicaid length-of-stay is calculated from CY 2001 Medicaid paid claims data.

Relative Weight Calculations

- Medicare Published Relative Weight * (Kentucky Medicaid Arithmetic Mean Length-of-Stay/Medicare Published Arithmetic Mean Length-of-Stay)
- Budget neutrality is defined as projected statewide aggregate payments under the DRG system will not exceed what estimated payments would have been under the current per diem system using the CY 2001 inpatient claims dataset.

Neonatal Relative Weights

A separate set of relative weights was developed for neonatal care at qualifying level III neonatal facilities using a similar methodology as described for all other relative weights.

Outlier Payment Calculations

- An additional payment is made for atypical cases that generate extremely high costs when compared to average cases in the same DRG.
- To qualify as an outlier, a hospital's charges for a case, adjusted to cost, must exceed the payment rate for the DRG by $29,000.
- The additional payment is equal to 80 percent of the difference between the hospital's entire cost for the stay and the threshold amount.

Transfer Cases

- Hospitals that transfer a patient to another hospital will receive a payment based on the standard DRG payment amount, but payment will be apportioned according to the patient's length-of-stay prior to discharge.

Postacute Care Transfer

- A qualified postacute care transfer case is a discharge from an inpatient hospital where the patient was:
  - Assigned one of 10 special DRG's
  - Transferred to an eligible postacute care setting
  - Provided postacute care service related to the condition or diagnosis for which the patient received inpatient hospital services.
  - Provided service within 3 days after the date of discharge.

Postacute Care Transfers

- Eligible postacute care settings:
  - Psychiatric, rehabilitation, children's long-term, or cancer hospitals;
  - Skilled nursing facility;
  - Home health services provided by a home health agency.
- Patients transferred to a swing-bed for skilled nursing care are not included.

3 Day Rule

The Medicare 3 day outpatient bundling rule has been adopted. Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), within 3 days prior to the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

3 Day Rule

254 - Drugs incident to other diagnostic services
255 - Drugs incident to radiology
30X - Laboratory
31X - Laboratory pathological
32X - Radiology diagnostic
341 - Nuclear medicine, diagnostic
35X - CT scan
40X - Other imaging services
46X - Pulmonary function

3 Day Rule

48X - Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93053, 93505, 93510, 93526, 93541, 93542, 93 543, 93544-93552, 93561, or 93562

53X - Osteopathic services

61X - MRI

62X - Medical/surgical supplies, incident to radiology or other diagnostic services

73X - EKG/ECG

74X - EEG

92X - Other diagnostic services

Out of State Payments

Out-of-state hospitals will be paid according to the in-state methodology. However, out-of-state hospitals will not receive payments for the costs of graduate medical education programs (indirect or direct)

DSH

The current year's DSH payment will be calculated under the existing methodology and distributed during the same time frames.

There will be a new payment methodology introduced for next year's DSH to be announced at a later date.